Quality Management Program Evaluation Summary

(AHCCCS Contract Year October 01, 2013 – September 30, 2014)

Bureau of Quality and Integration

Division of Behavioral Health Services

Contents

I. Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services henceforth known as DBHS implemented a Contract Year 2014 (CY14) Quality Management (QM) Plan describing the strategic direction of the DBHS QM program for CY14. The Plan and the Work Plan adopted seven goals. These goals are related to performance measures (those for the RBHAs and those for the Integrated RBHA); incident, accident and death (IAD) reports; performance framework and dashboard; performance improvement project; and oversight and monitoring. Goals were developed to be measurable, with detailed definitions given to strategies and correlating action items. The Bureau of Quality and Integration (BQ&I), conducted ongoing trending through quarterly reviews. Processes to analyze data to better understand causal relationships was developed by the Office of Information Management (OIM) who developed processes to take an active role in analyzing data received for all departments in BQ&I for the purpose of more robust data analysis and trending.

The seven goals adopted by BQ&I in the 2014 Work Plan were:

1. Performance Measures – 8 Behavioral Health and 23 Integrated Measures
2. Quality of Care Investigations: Behavioral Health and Integrated Care
3. AHCCCS-DBHS Current Mandated Collaborative Performance Improvement Projects
4. AHCCCS-DBHS Current Mandated Re-admissions within 30 days Performance Improvement Project (PIP)
5. Annual Consumer Survey
6. Oversight and Monitoring
7. Performance Framework and Dashboard

An explanation of each goal, with a description of the accompanying strategies and actions will ensue **Progress toward Goals in the FY 2014 Work Plan** will analyze the results of the activities taken to accomplish each goal/strategy. Whenever possible, trends identified through monitoring activities will be presented. For the purpose of continuous quality improvement, some goals will be brought forward to the new 2015 Work Plan (Attachment A). BQ&I presented all findings to the QM Committee for review and discussion. Recommendations from the QM Committee and Leadership Team concerning areas requiring additional focus will be added to the 2015 Work Plan.

II. Progress Toward Goals in the FY2014 Work Plan

Goal 1: Performance Measures: Behavioral Health

Performance Measure Results (DBHS)

CY 2014: Q1-Q4 (Aggregate)

Tables below are based on graph presentations previously reported in the DBHS Quarterly EPSDT, Adult and Performance Measure Monitoring Report. Minimum Performance Standards are listed in the tables below. The table below provides data for Q1 through Q4. Data and/or methodology concerns have been ongoing since January 1st of 2014. DBHS met with AHCCCS for technical assistance (TA) related to the operationalizing the methodology of the performance measures (PMs). During Q4, DBHS learned that there were issues related to the encounter data received - a backlog in processing submitted encounters and delays in provider submission of claims. As such, integrity of the data within the table and in the remaining performance measure tables is most likely compromised. It is difficult to report with certainty, the degree to which performance measures are met (or not met) for Q1 through Q3. Fourth quarter data will be calculated at a later date, based on resolution of encounter issues. Per AHCCCS approval, DBHS encounter data for Q4 performance measures, as well as a recalculation for Qs 1 through 3 will be run and submitted 30 calendars days after official notification from AHCCCS of encounter resolution.

Table # 1: Aggregate Performance Measure Results by Quarter

	1	2	3	4	5	6	7	8
Performance Measures	**Inpatient Utilization (days/1,000) (BH primary dx's)**	**ED Utilization (visits/1,000) (BH primary dx's)**	**Plan All-Cause Readmissions (BH primary dx's)**	**Follow-up after Hospitalization, 7 Days (BH primary dx's)**	**Follow-up after Hospitalization, 30 Days (BH primary dx's)**	**Access to Behavioral Health Provider within 7 days**	**Access to Behavioral Health Provider within 23 days**	**EPSDT Participation**
Minimum Performance Standard:	***480***	***1405***	***0.93***	***50%***	***70%***	***75%***	***90%***	***68%***
First Quarter Report: #	104673	931	1269	5169	6326	4496	11550	0
First Quarter Report: %	8/1,000	1/1,000	0.00	52%	64%	15%	37%	0
Second Quarter Report: #	82417	655	1167	3874	4859	3108	7755	0
Second Quarter Report: %	8/1,000	0/1,000	0.11	51%	64%	16%	39%	0
Third Quarter Report: #	62145	481	785	3500	4306	3679	9123	0
Third Quarter Report: %	6/1,000	0/1,000	0.06	79%	97%	16%	41%	0
Fourth Quarter Report: #	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Fourth Quarter Report: %	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD

Performance Measure Results (RBHA's)

CY2014: Q1 –Q4
Individual Measures by GSA

Table # 2: PM1: Inpatient Utilization

PM/MPS							
1.) Inpatient Utilization (B/H Primary) MPS-480	T/19 & T/21 Behavioral Health Inpatient Utilization (days per 1,000 member months)						
	GSA1	**GSA2**	**GSA3**	**GSA4**	**GSA5**	**GSA6**	**Statewide**
Q1							
Agg T19-days/MM	4	3	2	5	7	9	8
T21-days/MM	2	0	2	3	2	2	2
Agg T19-IP days	5146	1920	1307	3303	15645	77352	104673
T21-IP days	64	6	21	57	122	643	913
Q2	T/19 %T/21 Behavioral Health Inpatient Utilization						
Agg T19-days/MM	4	2	2	4	6	11	8
T21-days/MM	2	0	1	3	2	2	9
Agg T19-IP days	5464	1549	1014	2762	13054	58574	82417
T21-IP days	85	6	21	63	113	633	924
Q3	T/19 %T/21 Behavioral Health Inpatient Utilization						
Agg T19-days/MM	3	2	1	3	5	10	6
T21-days/MM	2	0	0	3	1	2	2
Agg T19-IP days	4717	1192	801	2178	10203	43051	62145
T21-IP days	85	0	50	54	54	507	705
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 3: PM2: ED Utilization

2.) ED Utilization (B/H Primary) MPS-1405	T/19 & T/21 Behavioral Health ED Utilization (days per 1,000 member months)						
	GSA1	GSA2	GSA3	GSA4	GSA5	GSA6	Statewide
Q1	T/19 & T21 Behavioral Health ED Utilization						
Agg T19-visits/MY	0	0	0	0	0	1	0
T21-/visits/MY	0	0	0	0	0	0	0
Agg T19-visits	7	0	7	0	214	703	931
T21-visits	0	0	0	0	0	4	4
Q2	T/19 & T21 Behavioral Health ED Utilization						
Agg T19-days/MY	0	0	0	0	0	0	0
T21-visits/MY	0	0	0	0	0	0	0
Agg T19-visits	4	0	4	0	172	475	655
T21-visits	0	0	0	0	0	4	4
Q3	T/19 & T21 Behavioral Health ED Utilization						
Agg T19-days/MM	0	0	0	0	0	1	0
T21-visits/MM	0	0	0	0	0	0	0
Agg T19-visits	3	0	4	2	131	341	481
T21-visits	0	0	0	0	0	2	2
Q4	Q4 data and analysis delayed due to encounter issues (TBD)						

Table # 4: PM3: Plan All-Cause Readmissions

Prior to Q3 CY14, the all cause readmission rate was calculated on a statewide basis only. In Q3, following technical assistance from AHCCCS regarding methodology, OIM began calculating the readmission rate separately for each RBHA in addition to the statewide calculation.

3.) Plan All-Cause Readmissions **MPS: 0.91**	T/19 & T/21 Behavioral Health Emergency Department Utilization (visits per 1,000 member years) Av. Adj. Prob - Obs/Exp Rate						
	GSA1	**GSA2**	**GSA3**	**GSA4**	**GSA5**	**GSA6**	**Statewide**
Q1	T/19 & T21 Behavioral Health ED Utilization						
Agg T19-AAP	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
T21-AAP	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
Agg T19-OEP	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
T21-OEP	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
Q2	T/19 & T21 Behavioral Health ED Utilization						
Agg T19-AAP	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
T21-AAP	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
Agg T19-OEP	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
T21-OEP	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
Q3	T/19 & T21 Behavioral Health ED Utilization						
Agg T19-AAP	0.06	0.06	0.06	0.06	0.06	0.06	0.06
T21-AAP	0.06	0.06	0.06	0.06	0.06	0.06	0.06
Agg T19-OEP	0.83	0.33	0.83	0.5	1.5	2	1.67
T21-OEP	0		0	4.17	2	0.67	0.83
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 5: PM4: Follow-up Post Hospitalization (7 Days)

4.) Follow-up post hospitalization (w/in 7 days – B/H primary) MPS: 50%	T/19 & T/21 Follow-up After Hospitalization for Mental Illness within 7 Days (showing those with apt within 7 Days) **% F/U Count**						
	GSA1	**GSA2**	**GSA3**	**GSA4**	**GSA5**	**GSA6**	**Statewide**
Q1	T/19 & T/21 Follow-up After Hospitalization w/in 7 Days						
Agg T19-%	38	73	66	58	57	52	52
T21-%	17	100	0	100	53	43	44
Agg T19-Appt in 7 days	230	44	65	141	924	3765	5169
T21-Appt in 7 days	1	1	0	3	8	42	55
Q2	T/19 & T/21 Follow-up After Hospitalization w/in 7 Days						
Agg T19-%	41	73	60	57	53	51	51
T21-%	25	100	0	50	57	56	53
Agg T19-Appt in 7 days	240	38	44	104	689	2759	3874
T21-Appt in 7 days	2	1	0	2	8	52	65
Q3	T/19 & T/21 Follow-up After Hospitalization w/in 7 Days						
Agg T19-%	72	89	83	86	83	78	79
T21-%	40	0	0	100	67	75	73
Agg T19-Appt in 7 days	225	31	38	98	667	2441	3500
T21-Appt in 7 days	2	0	0	3	4	45	54
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 6: PM5: Follow-up Post Hospitalization (30 Days)

5.) Follow-up post hospitalization (w/in 30 days – B/H primary) MPS: 70%	T/19 & T/21 Follow-up After Hospitalization for Mental Illness within 30 Days (showing those with apt within 30 days **% F/U Count**						
	GSA1	**GSA2**	**GSA3**	**GSA4**	**GSA5**	**GSA6**	**Statewide**
Q1	T/19 & T/21 Follow-up After Hospitalization w/in 30 Days						
Agg T19-%	52	82	77	66	69	63	64
T21-%	33	100	33	100	80	58	60
Agg T19-Appt in 30 days	315	49	76	161	1121	4604	6326
T21-Appt in 30 days	2	1	1	3	12	56	75
Q2	T/19 & T/21 Follow-up After Hospitalization w/in 30 Days						
Agg T19-%	56	79	73	66	68	63	64
T21-%	38	100	33	75	79	71	69
Agg T19-Appt in 30 days	325	41	53	120	883	3437	4859
T21-Appt in 30 days	3	1	1	3	11	66	85
Q3	T/19 & T/21 Follow-up After Hospitalization w/in 30 Days						
Agg T19-%	95	94	98	98	98	96	97
T21-%	100	0	0	100	100	97	97
Agg T19-Appt in 30 days	298	33	45	112	784	3034	4306
T21-Appt in 30 days	5	0	0	3	6	58	72
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 7: PM6: Access to Behavioral Health Provider (7 Days)

6.) Access to B/H Provider (w/in 7 days) MPS: 75%	T/19 & T/21 Access to Behavioral Health Provider within 7 Days (showing members seen within 7 days) **% F/U Count**						
	GSA1	**GSA2**	**GSA3**	**GSA4**	**GSA5**	**GSA6**	**Statewide**
Q1	T/19 & T/21 Access to BH Provider w/in 7 Days						
Agg T19-%	18	13	15	10	12	15	15
T21-%	16	8	24	8	4	10	10
Agg T19-Seen w/in 7 days	819	107	128	161	519	2762	4496
T21-Seen w/in 7 days	18	2	5	4	5	58	92
Q2	T/19 & T/21 Access to BH Provider w/in 7 Days						
Agg T19-%	20	13	15	11	13	16	16
T21-%	16	5	17	8	5	10	10
Agg T19-Seen w/in 7 days	707	93	106	135	438	1629	3108
T21-Seen w/in 7 days	14	1	3	4	5	45	72
Q3	T/19 & T/21 Access to BH Provider w/in 7 Days						
Agg T19-%	22	14	38	13	13	17	16
T21-%	23	13	0	13	3	11	11
Agg T19-Seen w/in 7 days	995	133	146	225	586	1593	3679
T21-Seen w/in 7 days	19	2	0	5	3	54	83
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 8: PM7: Access to Behavioral Health Provider (23 Days)

7.) Access to B/H Provider (w/in 23 days) MPS: 90%	T/19 & T/21 Access to Behavioral Health Provider within 23 Days (showing member seen within 23 days) **%** **F/U Count**						
	GSA1	**GSA2**	**GSA3**	**GSA4**	**GSA5**	**GSA6**	**Statewide**
Q1	T/19 & T/21 Access to B/H Provider w/in 23 Days						
Agg T19-%	43	26	34	38	30	38	37
T21-%	45	20	57	46	22	35	35
Agg T19-Seen w/in 23 days	1960	217	292	604	1319	7158	11550
T21-Seen w/in 23 days	52	5	12	24	25	211	329
Q2	T/19 & T/21 Access to B/H Provider w/in 23 Days						
Agg T19-%	46	26	36	38	33	40	39
T21-%	46	20	56	46	24	35	36
Agg T19-Seen w/in 23 days	1618	182	255	486	1106	4108	7755
T21-Seen w/in 23 days	40	4	10	23	22	165	264
Q3	T/19 & T/21 Access to B/H Provider w/in 23 Days						
Agg T19-%	50	32	38	42	32	41	41
T21-%	55	40	36	33	23	36	36
Agg T19-Seen w/in 23 days	2269	306	349	737	1471	3679	9123
T21-Seen w/in 23 days	61	6	4	13	25	272	272
Q4	**Q4 data and analysis delayed due to encounter issues - TBD**						
8.) EPSDT Participation	**Participation is at "0" due to behavioral health providers being unable to measure EPSDT visits (unclothed visit)**						

The Access to Behavioral Health Provider (BHP) 7 and 23 day measures caused extensive trepidation among the RBHAs who were concerned with their provider ability to meet the MPS due to the perceived restrictions of the measure, e.g. the need for BHPs to be registered with AHCCCS as a provider, the limited acceptable service codes, and the lack of inclusion of the 77 point of service code. DBHS and AHCCCS provided joint TA with the RBHAs related to the parameters and methodology of these two (2) measures. Discussions continued through July of 2014, at which point AHCCCS advised that there would be no changes to these two (2) measures for the 2015 Contract Year (CY).

Performance Measure Results Mercy Maricopa Integrated Care

CY2014 – Q1-Q4 EPSDT Tracking

Table # 9: EPSDT Tracking

EPSDT Tracking Form Requirements	EPSDT Tracking Forms 18 to 21 years old	TB Skin Test by PCP	Oral Health Screen by PCP	BMI Screening (for members aged 24 months and older)	Developmental Surveillance	Behavioral Health Referrals	CRS Referrals	Therapy Srvcs (PT/OT/ST)	Other
1st Quarter Report: %	no data	no data	no data	no data	no data	no data	no data	no data	no data
1st Quarter Report: #	no data	no data	no data	no data	no data	no data	no data	no data	no data
2nd Quarter Report: #	No data	no data	no data	no data	no data	no data	no data	no data	no data
2nd Quarter Report: %	no data	no data	no data	no data	no data	no data	no data	no data	no data
3rd Quarter Report: #	5	0	1	1	2	0	0	0	0
3rd Quarter Report: %		0	0.2	0.2	0.4	0	0	0	0
4th Quarter	Q4 data and analysis delayed due to encounter issues (TBD)								

Table # 10: Dental Services/Dental Home

Dental Measures	Preventive Dental Services (18 to 21 yrs)	Total EPSDT members assigned to a Dental Home (data should reflect quarterly assignments)
1st Quarter Report: %	no data	no data
1st Quarter Report: #	no data	no data
2nd Quarter Report: #	no data	no data
2nd Quarter Report: %	no data	no data
3rd Quarter Report: #	0	0
3rd Quarter Report: %	0	0
4th Quarter Report	Q4 data and analysis delayed due to encounter issues (TBD)	

Table # 11: EPSDT Provider Outreach

EPSDT Provider Outreach Requirements	EPSDT Reminder Notifications	Dental Reminders	Provider Incentives	Provider Newsletter (Provide Specifics in Narrative)	Provider Information on state and community services
1st Quarter Report: #	no data	no data	no data	no data	no data
2nd Quarter Report: #	no data	no data	no data	no data	no data
3rd Quarter Report: #	81	34	0	0	0
4th Quarter Report	Q4 data and analysis delayed due to encounter issues (TBD)				

Table # 12: EPSDT Member Outreach

EPSDT Member Outreach Requirements	EPSDT Reminder Notification	2nd EPSDT Reminder	Dental Reminder	2nd Dental Reminder	Member Incentives Provided (Provide	Member Newsletter (Provide specifics in	Other (provide specifics in narrative)	Dental Home
1st Quarter Report: #	no data	no data	no data	no data	no data	no data	no data	no data
2nd Quarter Report: #	no data	no data	no data	no data	no data	no data	no data	no data
3rd Quarter Report: #	0	0	0	0	0	0	0	0
4th Quarter Report	Q4 data and analysis delayed due to encounter issues (TBD)							

Performance Measure Results - Mercy Maricopa Integrated Care

CY2014 –Q1-Q4 Adult Provider Outreach/Adult Member Outreach

The performance measure tables below evidence the lack of available data for Mercy Maricopa. Due to their start date of 4/1/14, quarters 1 and 2 show "no data" in the table cells. For quarter 3, the only measure showing any data is the first Performance Measure related to Adult Provider Outreach. The remaining measures show "0" activity related to adult provider outreach. Additionally, member outreach data shows no activity.

Upon receipt of MMIC's Q3 Report, ADHS/DBHS conducted a series of meetings to provide technical assistance related to MMICs provision and tracking of these measures. Significant discussion took place regarding activities that could be reportable aspects of both provider and member outreach with special focus on integrative activities between the behavioral health and acute medical providers. DBHS has continued to work with Mercy Maricopa staff and leadership to provide technical assistance in an effort to increase Mercy Maricopa's understanding of methods to capture

outreach activities. This information is applicable to the results in Tables 11 and 12 above under EPSDT Provider and Member Outreach.

Table # 13: Adult Provider Outreach - Measures 1-5

PM/MPS – Adult Provider Outreach – Measures 1-5							
1.) Adult Provider Outreach	**Timeliness of Prenatal Care** **1**	**Diabetic Care: HbA1C** **2.a.**	**Diabetic Care: Eye Exam** **2.b.**	**Diabetic Care: LDL-C Screening** **2.c.**	**Adult Access to Preventive Ambulatory Care** **3**	**Chlamydia Screening** **4**	**Breast Cancer Screening** **5**
1st Quarter Report: #	No data	No data	No data	No data	No data	No data	No data
2nd Quarter Report: #	No data	No data	No data	No data	No data	No data	No data
3rd Quarter Report: #	29	0	0	0	0	0	0
4th Quarter Report:	**Q4 data and analysis delayed due to encounter issues**						

Table # 14: Adult Provider Outreach - Measures 6-10

Adult Provider Outreach Continued	**PM/MPS – Adult Provider Outreach – Measures 6-10**				
	Cervical Cancer Screening **6**	**Family Planning and STD Notification** **7**	**Provider Incentives** **8**	**Provider Newsletter** **9**	**Other (Provide Specifics in Narrative** **10**
1st Quarter Report: #	No data	No data	No data	No data	No data
2nd Quarter Report: #	No data	No data	No data	No data	No data
3rd Quarter Report: #	0	0	0	0	0
4th Quarter Report	**Q4 data and analysis delayed due to encounter issues (TBD)**				

Table # 15: Adult Member Outreach – Measures 1-5

PM/MPS – Adult Member Outreach – Measures 1-5							
1.) Adult Member Outreach	**Timeliness of Prenatal Care** **1**	**Diabetic Care: HbA1C** **2.a.**	**Diabetic Care: Eye Exam** **2.b.**	**Diabetic Care: LDL-C Screening** **2.c.**	**Adult Access to Preventive Ambulatory Care** **3**	**Chlamydia Screening** **4**	**Breast Cancer Screening** **5**
1st Quarter Report: #	No data	No data	No data	No data	No data	No data	No data
2nd Quarter Report: #	No data	No data	No data	No data	No data	No data	No data
3rd Quarter Report: #	0	0	0	0	0	0	0
4th Quarter Report	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 16: Adult Member Outreach – Measures 6-10

Adult Member Outreach Continued:	**PM/MPS – Adult Member Outreach – Measures 6-10**				
	Cervical Cancer Screening **6**	**Family Planning and STD Notification** **7**	**Member Incentives** **8**	**Member Newsletter** **9**	**Other (Provide Specifics in Narrative)** **10**
1st Quarter Report: #	No data	No data	No data	No data	No data
2nd Quarter Report: #	No data	No data	No data	No data	No data
3rd Quarter Report: #	0	0	0	0	0
4th Quarter Report	**Q4 data and analysis delayed due to encounter issues (TBD)**				

Adult Performance Measure Monitoring *Mercy Maricopa Integrated Care*

CY2014 – Q1-Q4 Individual Performance Measures 1-23

Tables 17 –20 below are indicative of MMICs Q3 Integrated PM report. Analysis and trends were not completed due to the newness of MMIC as the Integrated RBHA as well as issues with encounter data.

Table # 17: Individual Performance Measures – Measures 1-7

CY 2014 MMIC	**Performance Measure Monitoring: MMIC – SMI Integration 1-7**						
	Inpatient Utilization **1** MPS: 480	**ED Utilization (visits/1000)** **2** MPS: 1405	**Plan All-Cause Readmissions (Members aged 18+)** **3** MPS: 0.85	**Adult Asthma Admission Rate** **4** MPS: TBD	**Use of Appropriate Medications for People with Asthma** **5** MPS: 86%	**Follow-up After Hospitalization (7 days - all cause)** **6** MPS: 50%	**Follow-up After Hospitalization (30 days - all cause)** **7** MPS: 70%
1st Quarter Report #	No data	No data	No data	No data	No data	No data	No data
1st Quarter Report %	No data	No data	No data	No data	No data	No data	No data
2nd Quarter Report #	No data	No data	No data	No data	No data	No data	No data
2nd Quarter Report %	No data	No data	No data	No data	No data	No data	No data
3rd Quarter Report #	440	"under review"	"under review"	5	0	96	184
3rd Quarter Report %	3.84	"under review"	"under review"	0.01%	0	25.63%	48.94%
4th Quarter Report	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 18: Individual Performance Measures – Measures 8-13

CY 2014	Performance Measure Monitoring: MMIC – SMI Integration 8-13					
	Comprehensive Diabetes Care: Hemoglobin A1c Testing **8** MPS: 77%	**Comprehensive Diabetes Care: LDL Screening** **9** MPS: 70%	**Comprehensive Diabetes Care; Retinal Eye Exam** **10** MPS: 49%	**Flu Shots for Adults (Ages 50-64)** **11** MPS: 75%	**Flu Shots for Adults (Ages 65+)** **12** MPS: 75%	**Diabetes Short-term Complications Admission Rate** **13** MPS: TBD
1st Quarter Report #	No data	No data	No data	No data	No data	No data
1st Quarter Report %	No data	No data	No data	No data	No data	No data
2nd Quarter Report #	No data	No data	No data	No data	No data	No data
2nd Quarter Report %	No data	No data	No data	No data	No data	No data
3rd Quarter Report #	0	0	0	0	0	12
3rd Quarter Report %	0	0	0	0	0	0.01%
4th Quarter Report	**Q4 data and analysis delayed due to encounter issues (TBD)**					

Table # 19: Individual Performance Measures – Measures 14-19

CY 2014	Performance Measure Monitoring: MMIC – SMI Integration 14-19					
	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate **14** MPS: TBD	**Congestive Heart Failure Admission Rate** **15** MPS: TBD	**Annual HIV/AIDS Medical Visit** **16** MPS: 75%	**Annual Monitoring for Patients on Persistent Medications** **17** Tabled for CYE 2014	**Timeliness of Prenatal Care** **18** MPS: 80%	**Postpartum Care** **19** MPS: 64%
1st Quarter Report #	No data	No data	No data	No data	No data	No data
1st Quarter Report %	No data	No data	No data	No data	No data	No data
2nd Quarter Report #	No data	No data	No data	No data	No data	No data
2nd Quarter Report %	No data	No data	No data	No data	No data	No data
3rd Quarter Report #	9	5	98	No data	2	0
3rd Quarter Report %	0.01%	.01%		No data	0%	0%
4th Quarter Report	**Q4 data and analysis delayed due to encounter issues (TBD)**					

Table # 20: Individual Performance Measures – Measures 20-23

CY 2014	Performance Measure Monitoring: MMIC – SMI Integration 20-23			
	Access to PCP **20** MPS: 75%	**Access to Behavioral Health Provider w/in 7 days** **21** MPS: 75%	**Access to Behavioral Health Provider w/in 23 days** **22** MPS: 90%	**EPSDT Participation** **23** MPS: 68%
1st Quarter Report #	No data	No data	No data	No data
1st Quarter Report %	No data	No data	No data	No data
2nd Quarter Report #	No data	No data	No data	No data
2nd Quarter Report %	No data	No data	No data	No data
3rd Quarter Report #	"under review"	28	34	14
3rd Quarter Report %	"under review"	27.45%	33.33%	7.29%
4th Quarter Report	**Q4 data and analysis delayed due to encounter issues (TBD)**			

Performance Measure Results

CY2014: Q1-Q4 DDD/CMDP

Tables below for the Aggregate Performance Measure results are based on graph presentations previously reported within the Quarterly EPSDT, Adult and Performance Measure Monitoring Reports. Similar to the data and tables related to the Behavioral Health and Integrated RBHA PMs, encounter issues at the have also impacted data for the DDD and CMDP populations. Interpretation of this data due to under reporting of encounters leads to the potential for inappropriate interpretation of results. ADHS is working with AHCCCS to resolve data/encounter issues through an AHCCCS/ADHS Technical work group.

DDD/CMDP performance measure is also submitted to the Division of Developmental Disabilities on a quarterly basis.

Table # 21: CMDP Aggregate Performance Measure Results

	1	2	3	4	5	6	7	8
Performance Measures	**Inpatient Utilization (days/1,000) (BH primary dx's)**	**ED Utilization (visits/1,000) (BH primary dx's)**	**Plan All-Cause Readmissions (BH primary dx's)**	**Follow-up after Hospitalization, 7 Days (BH primary dx's)**	**Follow-up after Hospitalization, 30 Days (BH primary dx's)**	**Access to Behavioral Health Provider within 7 days**	**Access to Behavioral health provider within 23 days**	**EPSDT Participation**
Minimum Performance Standard:	***480***	***1405***	***0.91***	***50%***	***70%***	***75%***	***90%***	***68%***
First Quarter Report: #	4240	21	26	130	175	40	226	0
First Quarter Report: %	27%	2%	0.06	42%	56%	3%	15%	0
Second Quarter Report: #	3048	8	18	88	119	32	150	0
Second Quarter Report: %	26/1,000	0/1,000	0.07	41%	56%	3%	16%	0
Third Quarter Report: #	2654	5	15	80	116	30	175	0
Third Quarter Report: %	25/1,000	0	0.06	67%	97%	3%	15%	0
Fourth Quarter Report: #	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Fourth Quarter Report: %	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD

Table # 22: DDD Aggregate Performance Measure Results

	1	2	3	4	5	6	7	8
Performance Measures	**Inpatient Utilization (days/1,000) (BH primary dx's)**	**ED Utilization (visits/1,000) (BH primary dx's)**	**Plan All-Cause Readmissions (BH primary dx's)**	**Follow-up after Hospitalization, 7 Days (BH primary dx's)**	**Follow-up after Hospitalization, 30 Days (BH primary dx's)**	**Access to Behavioral Health Provider within 7 days**	**Access to Behavioral health provider within 23 days**	**EPSDT Participation**
Minimum Performance Standard:	*480*	*1405*	*0.91*	*50%*	*70%*	*75%*	*90%*	*68%*
First Quarter Report: #	2805	46	18	126	150	36	137	0
First Quarter Report: %	9%	2%	0.06%	54%	64%	5%	21%	0
Second Quarter Report: #	809	10	8	41	49	16	55	0
Second Quarter Report: %	6/1,000	0/1,000	0.09	57%	68%	6%	22%	0
Third Quarter Report: #	657	8	6	34	39	17	68	0
Third Quarter Report: %	5/1,000	0	0.06	87%	100%	7%	26%	0
Fourth Quarter Report: #	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Fourth Quarter Report: %	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD

DDD/CMDP Performance Measure Results CY2014: Q1-Q4

Individual Measures by GSA

Table # 23: PM1 – DDD/CMDP: IP Utilization

PM/MPS							
1.) Inpatient Utilization (B/H Primary) MPS-480	**DDD/CMDP Behavioral Health Inpatient Utilization (days per 1,000 member months)**						
	GSA1	**GSA2**	**GSA3**	**GSA4**	**GSA5**	**GSA6**	**Statewide**
Q1	DDD/CMDP Behavioral Health Utilization (days per 1,000 member months)						
T19 no subpops days/MM	3	3	2	5	7	9	7
T19-CMDP days/MM	55	39	32	19	28	24	27
T19-DDD days/MM	10	9	9	7	6	10	9
T19 no subpops IP days	4368	1724	1104	3033	14339	73060	97628
T19-CMDP IP days	528	128	128	165	1039	2252	4240
T19-DDD IP days	250	68	75	105	267	2040	2805

Q2	DDD/CMDP Behavioral Health Utilization (days per 1,000 member months)						
T19 no subpops days/MM	4	2	2	4	6	11	8
T19-CMDP days/MM	65	37	17	16	25	22	26
T19-DDD days/MM	10	5	9	7	3	5	6
T19 no subpops IP days	4613	1389	870	2521	11945	57222	78560
T19-CMDP IP days	610	126	69	142	949	1152	3048
T19-DDD IP days	241	34	75	99	160	200	809
Q3	DD/CMDP Behavioral Health Utilization (days per 1,000 member months)						
T19 no subpops days/MM	3	2	1	3	4	4	10
T19-CMDP days/MM	60	42	1	9	23	22	25
T19-DDD days/MM	9	3	13	4	2	5	5
T19 no subpops IP days	3922	1027	598	2037	9234	42016	58834
T19-CMDP IP days	581	145	100	78	880	870	2654
T19-DDD IP days	214	20	103	63	92	165	657
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 24: PM2 – DDD/CMDP: ED Utilization

2.) ED Utilization (B/H Primary) MPS-1405	**DDD/CMDP Behavioral Health ED Utilization**						
	GSA1	**GSA2**	**GSA3**	**GSA4**	**GSA5**	**GSA6**	**Statewide**
Q1	DDD/CMDP Behavioral Health ED Utilization (visits per 1,000 Member Years)						
T19 – no subpops visits/MY	0	0	0	0	1	1	1
T19 CMDP Visits/MY	1	0	0	0	0	3	2
T19 DDD Visits/MY	0	0	1	0	1	3	2
T19 no subpops Visits	6	0	6	0	210	642	864
T19 CMDP Visits	1	0	0	0	0	20	21
T19 DDD Visits	0	0	1	0	4	41	46
Q2	DDD/CMDP Behavioral Health ED Utilization (days per 1,000 member months)						
T19 – visits/MM No subpops	No ED Visits to report for Q2FY14 when calculated at rate per 1,000 Member Months						
T19 CMDP Visits/MM							

T19 Visits/MM	0	0	0	0	0	0	0
T19 CMDP Visits/MM	0	0	0	0	0	0	0
T19 DDD Visits/MM	0	0	0	0	0	0	0
T19 Visits	3	0	3	0	171	460	637
Q3	DDD/CMDP Behavioral Health ED Utilization (days per 1,000 member months)						
T19 – no subpops visits/MM	0	0	0	0	0	1	0
T19 CMDP Visits/MM	0	0	0	0	0	0	0
T19 DDD Visits/MM	0	0	0	0	0	1	0
T19 visits	2	0	3	2	130	331	468
T19 CMDP Visits	1	0	0	0	0	4	5
T19 DDD visits	0	0	1	0	1	6	8
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 25: PM1 – DDD/CMDP: Plan All-Cause Readmissions

3.) Plan All-Cause Readmissions MPS: 0.91	**DDD/CMDP Plan All-Cause Readmissions** **Av. Adj. Prob (AAP) - Obs/Exp Rate (OEP)**						
	GSA1	**GSA2**	**GSA3**	**GSA4**	**GSA5**	**GSA6**	**Statewide**
Q1	DDD/CMDP Plan All-Cause Readmissions						
T19 no subpops AAP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
T19 CMDP AAP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
T19 DDD AAP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
T19 no subpops OEP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
T19 CMDP OEP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology

T19 DDD OEP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
Q2	DD/CMDP Plan All-Cause Readmissions						
T19 no subpops AAP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
T19 CMDP AAP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
T19 DDD AAP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
T19 no subpops OEP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
T19 CMDP OEP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
T19 DDD OEP	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology	No Analysis due to change in methodology
Q3	DDD/CMDP Plan All-Cause Readmissions						
T19 no subpops AAP	0.06	0.06	0.06	0.06	0.06	0.06	0.06
T19 CMDP AAP	0.06	0.06	0.06	0.06	0.06	0.06	0.06
T19 DDD AAP	0.06	0.06	0.06	0.06	0.06	0.06	0.06
T19 no subpops OEP	0.83	0.17	0.17	0.50	1.50	2.00	1.67
T19 CMDP OEP	0.50	3.33	3.33	1.83	1.33	1.00	1.17
T19 DDD OEP	1.83	5.00	3	0.00	1.33	0.00	1.50
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 26: PM1 – DDD/CMDP: F/U Hospitalization (7 Days)

4.) Follow-up post hospitalization (w/in 7 days – B/H primary) MPS: 50%	DDD/CMDP Follow-up After Hospitalization for Mental Illness within 7 Days (showing those with apt within 7 Days) % F/U Count						
	GSA1	GSA2	GSA3	GSA4	GSA5	GSA6	Statewide
Q1	DDD/CMDP Follow-up After Hospitalization w/in 7 Days						
T19 no subpops %	39	73	66	56	58	52	52
T19 CMDP %	29	75	67	75	41	39	42
T19 DDD %	41	0	67	70	69	51	54
T19 no subpops – f/u count	217	41	57	122	874	3602	4913
T19 CMDP f/u count	6	3	4	12	32	73	130
T19 DDD f/u count	7	0	4	7	18	90	126
Q2	DDD/CMDP Follow-up After Hospitalization w/in 7 Days						
T19 no subpops %	42	73	59	56	54	51	51
T19 CMDP %	27	75	75	62	42	38	41
T19 DDD %	39	0	67	67	56	65	57
T19 no subpops – f/u count	227	35	37	90	650	2706	3745
T19 CMDP f/u count	6	3	3	8	30	38	88
T19 DDD f/u count	7	0	4	6	9	15	41
Q3	DDD/CMDP Follow-up After Hospitalization w/in 7 Days						
T19 no subpops %	73	91	79	88	84	78	79
T19 CMDP %	55	67	100	78	73	62	67
T19 DDD %	71	0	100	60	86	100	87
T19 no subpops – f/u count	214	29	31	88	629	2395	3386
T19 CMDP f/u count	6	2	1	7	32	32	80
T19 DDD f/u count	5	0	6	3	6	14	34
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 27: PM1 – DDD/CMDP: F/U Hospitalization (30 Days)

5.) Follow-up post hospitalization (w/in 30 days – B/H primary) MPS: 70%	DDD/CMDP Follow-up After Hospitalization for Mental Illness within 30 Days (showing those with apt within 30 days % F/U Count						
	GSA 1	GSA2	GSA3	GSA 4	GSA5	GSA6	Statewide
Q1	DDD/CMDP Follow-up After Hospitalization w/in 30 days						
T19 no subpops %	52	80	77	64	70	63	64
T19 CMDP %	57	100	67	88	57	52	56
T19 DDD %	59	0	83	80	77	61	64
T19 no subpops – f/u count	293	45	67	139	1056	4401	6001
T19 CMDP f/u count	12	4	4	14	45	96	175
T19 DDD f/u count	10	0	5	8	20	107	150
Q2	DDD/CMDP Follow-up After Hospitalization w/in 30 days						
T19 no subpops %	56	77	71	64	69	64	64
T19 CMDP %	55	100	75	77	55	51	56
T19 DDD %	50	0	83	78	69	74	68
T19 no subpops – f/u count	304	37	45	103	833	3369	4691
T19 CMDP f/u count	12	4	3	10	39	51	119
T19 DDD f/u count	9	0	5	7	11	17	49
Q3	DDD/CMDP Follow-up After Hospitalization w/in 30 days						
T19 no subpops %	95	94	97	100	98	96	97
T19 CMDP %	100	100	100	100	98	94	97
T19 DDD %	100	0	100	100	100	100	100
T19 no subpops – f/u count	214	30	38	9	734	2971	4151
T19 CMDP f/u count	11	3	1	9	43	49	116
T19 DDD f/u count	7	0	6	5	7	14	39
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 28: PM1 – DDD/CMDP: Access to B/H Provider (7 Days)

6.) Access to B/H Provider (w/in 7 days) MPS: 75%	DDD/CMDP Access to Behavioral Health Provider within 7 Days (showing members seen within 7 days) % F/U Count						
	GSA1	GSA2	GSA3	GSA4	GSA5	GSA6	Statewide
Q1	DDD/CMDP Access to Behavioral Health Provider w/in 7 Days						
T19 no subpops %	19	13	15	11	12	16	15
T19 CMDP %	3	0	4	2	2	3	3
T19 DDD %	7	10	15	5	5	5	5
T19 no subpops Total w/in 7 days	810	106	125	159	511	2709	4420
T19 CMDP Total w/in 7 days	5	0	1	1	3	30	40
T19 DDD Total w/in 7 days	4	1	2	1	5	23	36
Q2	DDD/CMDP Access to Behavioral Health Provider w/in 7 Days						
T19 no subpops %	21	13	15	11	13	17	16
T19 CMDP %	4	0	4	2	2	4	3
T19 DDD %	9	11	17	0	7	4	6
T19 no subpops Total w/in 7 days	697	92	103	134	431	1603	3060
T19 CMDP Total w/in 7 days	6	0	1	1	2	22	32
T19 DDD Total w/in 7 days	4	1	2	0	5	4	16
Q3	DDD/CMDP Access to Behavioral Health Provider w/in 7 Days						
T19 no subpops %	23	14	16	14	13	18	17
T19 CMDP %	3	5	2	0	4	2	3
T19 DDD %	11	0	29	0	3	5	7
T19 no subpops Total w/in 7 days	982	132	141	223	577	1574	3632
T19 CMDP Total w/in 7 days	7	1	1	0	6	15	30
T19 DDD Total w/in 7 days	6	0	4	0	3	4	17
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						

Table # 29: PM1 – DDD/CMDP: Access to B/H Provider (23 Days)

7.) Access to B/H Provider (w/in 23 days) MPS: 90%	DDD/CMDP Access to Behavioral Health Provider within 23 Days (showing member seen within 23 days) % F/U Count						
	GSA 1	GSA2	GSA3	GSA4	GSA5	GSA6	Statewide
Q1	DDD/CMDP Access to B/H Provider w/in 23 Days						
T19 no subpops %	19	13	15	11	12	16	15
T19 CMDP %	3	0	4	2	2	3	3
T19 DDD %	7	10	15	5	5	5	5
T19 no subpops Total w/in 23 days	810	106	125	159	511	2709	4420
T19 CMDP Total w/in 23 days	5	0	1	1	3	30	40
T19 DDD Total w/in 23 days	4	1	2	1	5	23	36
Q2	DDD/CMDP Access to B/H Provider w/in 23 Days						
T19 no subpops %	48	26	37	39	34	42	40
T19 CMDP %	17	0	17	24	9	16	16
T19 DDD %	24	22	33	7	16	26	22
T19 no subpops Total w/in 23 days	1581	180	247	474	1084	3984	7550
T19 CMDP Total w/in 23 days	26	0	4	11	10	99	150
T19 DDD Total w/in 23 days	11	2	4	1	12	25	55
Q3	DDD/CMDP Access to B/H Provider w/in 23 Days						
T19 no subpops %	23	14	16	14	13	18	17
T19 CMDP %	3	5	2	0	4	2	3
T19 DDD %	11	0	29	0	3	5	7
T19 no subpops Total w/in 23 days	982	132	141	226	577	1574	3632
T19 CMDP Total w/in 23 days	7	1	1	0	6	15	30
T19 DDD Total w/in 23 days	6	0	4	0	3	4	17
Q4	**Q4 data and analysis delayed due to encounter issues (TBD)**						
8.) EPSDT Participation	**Participation is at "0" due to behavioral health providers being unable to measure EPSDT visits (unclothed visit)**						

GOAL RESULT: It is difficult to ascertain whether the performance measure goals have been partially met or not met due to data concerns and methodology changes during quarters 1 through 3. The use of HEDIS (Inpatient Utilization and Ambulatory Care), Adult Core, and Children's Core methodology was a new way for the RBHAs and DBHS to monitor performance.

Behavioral Health Service Plan - Adult and Children –

A Statewide performance improvement initiative to improve the Behavioral Health Service Plan (BHSP) performance measure began in April 2012. Based on a root cause analysis, it was determined that there was no process in place to ensure that all components of the service plan were completed. A "Checklist" was developed and implemented as a performance improvement initiative that focused on ensuring that all components of the behavioral health service plan were completed. Contractor performance on the Behavioral Health Service Plan performance measures were tracked and trended, and based on the implementation date of the checklist, statewide improvement in the service plan performance measure was associated with the checklist initiative. After closer examination of the methodology used to calculate the BHSP measure utilizing the FOCUS-PDSA model, it was decided to re-vamp the BHSP measure. The updated BHSP measure is located in the Specifications Manual (Attachment K).

The following two tables provide data for Service Plan analysis for Quarter 1 and Quarter 2. Quarters 3 and 4 are currently under review. Delays in BHSP reviews s are the result of updates needed to be made to the existing datase to accommodate methodological changes made in CY14.

It can be seen that none of the RBHA's met the minimum performance standard of 85%. The statewide average for Q1 is 74.5% for adults and for children it is 62.1%. For the second quarter, percentage scores are 71.8% (adults) and 68.6% (children).

Table # 30: Statewide Percent of Service Plan Record Review

GSA/RBHA **MPS: 85%**	Behavioral Health Service Plan Statewide Percent of Records Review with a Current/Complete Service Plan that Included Services from the Assessment						
	GSA1 **NARBHA**	**GSA2** **Cenpatico**	**GSA3** **Cenpatico**	**GSA4** **Cenpatico**	**GSA5** **CPSA**	**GSA6** **Magellan**	**Statewide**
Q1 **Adults**	Adult Data for Records Reviewed with a Current/Complete Service Plan						
Num./Denom.	52/65	49/62	39/63	49/64	50/66	No Report	239/320
Percentage	80%	79%	61.9%	76.6%	75.8%	No Report	75%
Q2 **Adults**	Adult Data for Records Reviewed with a Current/Complete Service Plan						
Num./Denom.	50/65	34/62	45/63	46/63	54/66	No Report	229/319
Percentage	77%	55%	71%	73%	82%	No Report	72%
Q1 **Children**	Children's Data for Records Reviewed with a Current/Complete Service Plan						
Num./Denom.	44/62	32/61	31/61	32/65	34/65	No Report	173/314
Percentage	72%	53%	51%	49%	52%	No Report	55%
Q2 **Children**	Children's Data for Records Reviewed with a Current/Complete Service Plan						
Num./Denom.	44/63	40/61	39/63	43/65	52/66	No Report	218/318
Num./Denom.	70%	66%	62%	66%	79%	No Report	69%

The results for Q1 and Q2 were shared with each RBHA with comments for individual service plans as appropriate. Although specific member information (name, DOB, ID) was removed, the comments were detailed enough to allow RBHA's to trend issues by provider. The charts were

reviewed not only for whether or not services were provided based on services identified within the Assessment, but they were also reviewed for documentation of service billing codes. The requirement for providers to include billing codes and service description became effective October 01, 2013. If codes were missing or incorrect, providers were referred (via the comment section) to the ADHS/DBHS Behavioral Health Services Guide. The Office of Performance Improvement will be tracking and trending to assess the level to which services listed in the service plan are encountered in the system.

Performance on the BHSP for Adults and Children receiving services through the Department of Developmental Disabilities (DDD), as well as for Children receiving services through the Comprehensive Medical and Dental Program (CMDP) is difficult to evaluate due to the small numbers represented in the total "n" for the measure. Contractual requirements for FY14 with AHCCCS and DDD resulted in the need to ensure that a representative sample was drawn for each performance measure based upon population/payer source. Despite the current analysis based on updated methodology to account for a representative sample, results in the table below continue to reflect a small sample size. As such, challenges in data interpretation remain.

Table # 31: Service Plan Results DDD/CMDP

RBHA	FY14 Quarter	DDD Adults	DDD Children	CMDP
GSA1	Q1	33.3%	75%	100%
NARBHA	Q2	33.3%	50%	80%
GSA2	Q1	100%	25%	42.9%
Cenpatico	Q2	50%	33.3%	87.5%
GSA3	Q1	100%	66.7%	45.5%
Cenpatico	Q2	66.7%	100.%	58.3%
GSA4	Q1	50%	50%	50.0%
Cenpatico	Q2	100%	100%	78.6%
GSA5	Q1	50%	33.3%	45.0%
CPSA	Q2	100%	100%	77.8%
Statewide	Q1	66.7%	50%	51.7%
	Q2	63.6%	80%	75.8%

Due to the need for sustainable improvement by RBHA providers to maintain the MPS, DBHS will continue the BHSP as a performance measure in FY15.

GOALS RELATED TO BHSP PARTIALLY MET

Behavioral Health Service Provision - Adult and Children –

The Behavioral Health Service Provision (BHSPv) performance measure focuses on measuring whether members receive the services recommended in their service plans. The results are based on encounters that have been submitted for provided services.

The BHSPv measure was updated in CY2014 with the intention of capturing the services members receive compared to what has been documented in their service plan. The denominator of this measure consists of all of the records submitted for the BHSP review. The codes entered into the BHSP database identifying the recommended service are matched with encounter codes for the review period. Direct code matches result in "passing" the measure. BIS also supplies additional code information for each record. The results for Q1 & Q2 for CY14 are below.

Table #32: BHSPv Results for Adults and Children by RBHA and Statewide

GSA/RBHA MPS: 85%	Behavioral Health Service Provision Statewide Percent of Records Review with a direct match of service codes identified in the Service Plan Review						
	GSA1 NARBHA	**GSA2 Cenpatico**	**GSA3 Cenpatico**	**GSA4 Cenpatico**	**GSA5 CPSA**	**GSA6 Magellan**	**Statewide**
Q1 Adults	Adult Data for Records Reviewed with a Current/Complete Service Plan						
Num./Denom	8/65	3/62	11/63	9/64	21/66	No Report	52/315
Percentage	12%	5%	17%	14%	32%	No Report	17%
Q2 Adults	Adult Data for Records Reviewed with a Current/Complete Service Plan						
Num./Denom	5/65	5/62	15/63	8/63	13/66	No Report	46/319
Percentage	8%	8%	24%	13%	20%	No Report	14%
Q1 Children	Children's Data for Records Reviewed with a Current/Complete Service Plan						
Num./Denom	14/62	16/61	10/61	14/65	3/63	No Report	55/312
Percentage	23%	26%	16%	22%	5%	No Report	18%
Q2 Children	Children's Data for Records Reviewed with a Current/Complete Service Plan						
Num./Denom	8/63	12/61	13/63	18/65	9/66	No Report	59/313
Num./Denom	13%	20%	21%	28%	14%	No Report	19%

Table # 33: BHSPv results for DDD Adults and Children, and CMDP members

RBHA	FY14 Quarter	DDD Adults	DDD Children	CMDP
GSA1 **NARBHA**	Q1	0%	25%	33.3%
	Q2	0%	0%	40%
GSA2 **Cenpatico**	Q1	0%	25%	57.1%
	Q2	0%	33.3%	37.5%
GSA3 **Cenpatico**	Q1	50%	0%	0%
	Q2	33.3%	0%	8.3%
GSA4 **Cenpatico**	Q1	0%	50%	28.6%
	Q2	0%	0%	50.6%
GSA5 **CPSA**	Q1	0%	0%	0%
	Q2	50%	0%	16.7%
Statewide	Q1	8.3%	22.2%	17.2%
	Q2	18.2%	6.7%	29.0%

Results of the BHSPv measure are quite low. Statewide results indicate that children are receiving more services identified on their service plan than adults. Statewide results for DDD members indicate that in Q1, children had more identified services indicated on their service plan than adult DD members. The opposite was true for the DDD population in Q2 of CY14.

The CMDP population statewide results for Q2 indicated that 29% of the CMDP members received services as identified on their service plan.

As this is a new method of reviewing the BHSPv results. No conclusions can be made regarding the results. A workgroup will begin in January of 2015 to examine the results, the methodology, and the programming to determine if any changes need to take place in the logic behind the PM. Adjustments to the BHSPv PM will be captured in the 2QCY15 Work Plan.

GOAL NOT MET

III. Goal 2: Quality of Care Investigations: Behavioral Health Integrated Care

During FY2013, with the restructuring of how Quality of Care (QOC) investigations were initiated, investigated and validated, it was determined by AHCCCS that QOC investigations should not require any more than 30 days for completion of the investigation and resolution report. The new standard was given to the T/RBHA contractors, coupled with a series of changes in procedure, to improve the final resolution report product. However, the systemic changes in process required a significant increase in technical assistance required by the T/RBHAs, and consequently cases became overdue.

A QM Plan goal for FY2014 was implemented as a result of a large number of overdue resolution reports, to increase the timely completion of T/RBHA-submitted Quality of Care Resolution Reports over the baseline measurement of compliance with the AHCCCS-mandated 20-day timeline. A new QOC Policy was written and released in FY2014, along with a new Peer Review Policy and a DBHS Quality of Care/Peer Review Desktop Protocol outlining the requirements of submitting QOC Resolution Reports.

The changes in Policies and Procedures, while necessary for improvement, brought corollary challenges and barriers to completing the reports on time. During FY2014, DBHS BQ&I aggressively met the challenges faced by these barriers by identifying every possible barrier to not only BQ&I catching up to the QOC cases that were delinquent, but to helping the T/RBHAs in adjusting to the changes as well.

Among the changes designed and implemented, BQ&I:

- Hired a new Office Chief for the Office of Quality of Care in April, 2014
- Hired additional QOC staff members to a current team of 6 Registered Nurses, diversified in experience and skill sets to meet the challenges of overseeing the QM functions of Integrated RBHAs, along with a temporary, part-time QOC Specialist and a temporary, part-time QOC data assistant
- Developed and implemented an electronic, exportable PDF Incident, Accident and Death (IAD) Report form, and mandated its use by all providers statewide
- Developed and implement a standardized, exportable Resolution Report template and mandated its use by all T/RBHA QM staff
- Developed and implemented template forms for all outgoing letters from DBHS to ensure consistency, efficiency and accuracy in reporting information to AHCCCS, T/RBHAs, Division of Developmental Disabilities and other stakeholders.
- Initiated a large-scale multi-faceted project to build an innovative, revolutionary web-based portal that will synchronize and standardize even further all IAD and QOC processes statewide, which is scheduled to begin use in January, 2015

As a result of this leadership, strong teamwork and strategic planning, overdue QOC cases are virtually an issue of the past, and DBHS is in a much better position to hold the T/RBHAs accountable to a 30-day timeframe for completion of QOC resolution reports.

DBHS plans to keep this goal, now having the means to reach and enforce it.

IV. Goal 3: AHCCCS-DBHS Current Mandated Collaborative Performance Improvement Project (PIP)

The ultimate goal of this Performance Improvement Project (PIP) is to improve coordination of care provided to AHCCCS members who are receiving both medical and behavioral health services through the exchange of opiate and benzodiazepine prescribing and other clinical information between medical and behavioral health providers, in order to reduce morbidity and/or mortality among these members.

Coordination of Care (CoC) PIP

DBHS hosted and facilitated the CoC work group subcommittee meetings as well as the larger CoC AHCCCS Acute Care Plan/RBHA collaboration meetings.

A number of interventions were put into place, including but not limited to, letter communiqués between Health Plan and RBHA outlining pharmacy utilization, treatment and treatment plans; and the development of data sharing via Mercy Maricopa Integrated Care (MMIC) RBHA for Maricopa County.

AHCCCS closed the CoC PIP during the 2014 Contract year. However, despite the PIP closure, the RBHAs and Health Plans have all agreed to continue with the coordination efforts that have been put into place. Participants of the CoC work group expressed satisfaction with the accomplishments and collaborative efforts of the group.

For a more in-depth discussion related to the CoC PIP, see Attachment O.

GOAL MET

V. Goal 4: AHCCCS-DBHS Current Mandated 30-day Readmissions Performance Improvement Project PIP

The purpose of this Performance Improvement Project is to decrease the rate of inpatient readmissions among AHCCCS members within 30 days of a previous discharge, in order to improve quality of life, promote patient-centered care, and reduce unnecessary health care utilization and costs.

Re-admission rates over the past 2 years have remained relatively stable, resulting in AHCCCS closing the Re-admission PIP in CY2014.

A more detailed analysis related to the Re-admission PIP can be found in Attachment P.

GOAL MET

VI. Goal 5: Annual Consumer Survey

The goal of the Annual Consumer Survey is to request independent feedback from Title XIX/XXI adults and families of youth receiving services through Arizona's publicly funded behavioral health system. The surveys measure consumers' perceptions of behavioral health services in relation to eight (8) domains:

- General Satisfaction
- Access to Services
- Service Quality/Appropriateness
- Participation in Treatment
- Outcomes
- Cultural Sensitivity
- Improved Functioning
- Social Connectedness

The objective is to use the Annual Consumer Survey as a critical source of information to drive system improvements through RBHA contracts and QM Plans

Adult Consumer Survey results:

Statewide:

- The *Service Access* domain remained unchanged from 2013.
- The *Participation in Treatment Planning, Service Quality & Appropriateness, Outcomes*, and *Improved Functioning* domains showed increases of 1 to 2 percentage points. *The Social Connectedness* domain increased by 5 percentage points, a statistically significant increase.
- The *General Satisfaction* domain decreased by 2 percentage points.

RBHA Specific:

- NARBHA (GSA 1) showed increases or decreases of 1 to 3 percentage points in all domains; none were statistically significant.
- Cenpatico's (GSA 2, 3, 4) scores varied from -8 percentage points to +6 percentage points as compared to domain scores in 2013, with a statistically significant increase in GSA 3's *Social Connectedness* domain and a statistically significant decrease in GSA 4's *Outcomes* domain. GSA 4 experienced a decrease in all domains this year.
- CPSA's (GSA 5) score for the *General Satisfaction* domain remained unchanged from 2013 and all other domains increased from 2 to 8 percentage points, with the 8 point increase in the *Social Connectedness* domain being statistically significant.

YSS-F Consumer Survey results:

Statewide:

- All domains experienced increases in positive scores, none of which were statistically significant.

RBHA Specific:

- NARBHA experienced an increase of 2 percentage points in *General Satisfaction* with no changes in the *Outcomes* or *Social Connectedness* domains. Decreases in the remaining domains were noted, none of which were statistically significant.
- Cenpatico's domain scores varied from -7 to +5 percentage points as compared to last year, with a statistically significant increase in GSA 2's *Social Connectedness* domain and a statistically significant decrease in GSA 4's *Outcomes* domain.
- CPSA (GSA 5) experienced changes ranging from -4 to +3 percentage points, none of which were statistically significant.

A more detailed analysis related to the Annual Consumer Survey can be found in Attachment M

GOAL SUBSTANTIALLY MET

VII. Goal 6: Monitoring and Oversight Activities

ADHS will improve the service delivery system for behavioral health recipients/members

DBHS efforts to improve the service delivery for behavioral health members focused not only on the frequency that ADHS/DBHS QM reviews Contractor data, conducts validation reviews and implements corrective actions, but on the process used to monitor RBHA activities.

DBHS developed five (5) strategies to meet FY14 Goal on Monitoring and Oversight Activities. This goal was met through DBHS performing the following activities:

- Provider Monitoring
- Quality of Care
- Peer Review
- Credentialing

  Medical Record Review

Provider Monitoring

- The QM/PI Program scope of monitoring and evaluation must be comprehensive. It must incorporate the activities used by the Contractor, and demonstrate how these activities will improve the quality of services and the continuum of care in all service sites.
- Information and data gleaned from QM monitoring and evaluation that shows trends in quality of care issues should be used in developing PI projects. Selection of specific monitoring/evaluation activities should be appropriate to each specific service site.
- Contractors must develop work plans for taking appropriate actions to improve care if problems are identified
- DBHS conducted the 2014 Annual Administrative Review of the T/RBHAs between the months of September through November for the timeframe of July 01, 2012 through June 30 of 2013. OPI and OQC performed a combination of onsite and remote document and record reviews based upon the Standard. Due to the delay in implementation, Mercy Maricopa Integrated Care (MMIC), the GSA 6 Integrated RBHA, was reviewed for the time period of April 01 through September 30, 2014 as a means of gauging the service provision and activities of the new RBHA. The MMIC review used a combination of T/RBHA behavioral health Standards, and AHCCCS Acute Care Standards.
- An exit interview was conducted at the end of each onsite T/RBHA Administrative Review with T/RBHA staff to provide preliminary feedback, and a performance update.

Annual Admin Review

ADHS/DBHS conducts an Administrative Review (similar to AHCCCS' Operational Review) of its contracted Tribal and Regional Behavioral Health Authorities each year. The QM Section standards are mainly focused on T/RBHA compliance with QM Structure, Governing Body, QOC and IAD process, Credentialing/ Re-credentialing, Peer Review Processes and Medical Record Review.

DBHS conducted an annual Administrative Review to monitor and oversee RBHA Quality of Care, Peer Review, and Credentialing. Administrative Review was completed from September 2014 through

November 2014. Draft scores will soon be submitted to all Contractors and a challenge period will be granted prior to finalization of scores and issuance of CAPs for deficient standards. RBHAs will be placed on a Corrective Action Plan for all Standards falling below a score of 90%. The CAP will be lifted upon two consecutive quarters of acceptable improvement.

Table # 34: FY14 Preliminary Scores for RBHA Administrative Review Results

RBHA FY14 QM – QM Administrative Review Scores

ADHS/DBHS Standard	MMIC	NARBHA	Cenpatico	CPSA
QM1: The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for member/system resolution.	86% SC	100% FC	100% FC	100% FC
QM2: The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for system improvement.	80% SC	100% FC	100% FC	100% FC
QM5: The governing body and the Contractor are accountable for all Quality Management/Quality Improvement (QM/QI) program functions.	100% FC	100% FC	100% FC	100% FC
QM6: The Contractor has the appropriate staff employed to carry out Quality Management Program administrative requirements.	100% FC	100% FC	100% FC	100% FC
QM7: The Contractor has a structure in place for a Quality Management Program that includes administrative requirements related to policy development.	100% FC	100% FC	100% FC	100% FC
QM8: The Contractor has a structure in place for a Quality Management Program that includes administrative requirements related to the peer review process.	75% SC	100% FC	100% FC	100% FC
QM9: The Contractor ensures credentialing, re-credentialing, and provisional credentialing of the providers in their contracted provider network.	100% FC	100% FC	100% FC	100% FC
QM10: The Contractor's provisional credentialing process meets the AHCCCS required timelines.	100% FC	100% FC	100% FC	100% FC
QM11: The Contractor ensures the credentialing and re-credentialing of providers in the contracted provider network.	100% FC	100% FC	100% FC	100% FC
QM12: The Contractor has a process for verifying credentials of all organizational providers. (Including but not limited to: hospitals, behavioral health residential treatment facilities, transportation, attendant care, group homes, etc.)	100% FC	100% FC	100% FC	100% FC
QM13: The Contractor has a structure in place for a Quality Management Program that includes administrative requirements for oversight and accountability for all functions and responsibilities described in ADHS/DBHS Policy and AMPM Chapter 900 that are delegated to other entities.	100% FC	100% FC	100% FC	100% FC
QM14: The Contractor conducts a new member health risk assessment survey.	50% PC	100% FC	100% FC	100% FC
QM15: The Contractor identifies specific health care needs through the new member health risk assessment survey.	0% NC	100% FC	100% FC	100% FC
QM16: The Contractor maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its QM/QI Program.	0% NC	100% FC	100% FC	100% FC

ADHS/DBHS Standard	MMIC	NARBHA	Cenpatico	CPSA
QM17: The health information system data elements include at least the following information to guide the selection of and meet the data collection requirements for quality improvement requirements.	50% PC	100% FC	100% FC	100% FC
QM18: The Integrated Contractor monitors that PCPs and Behavioral Health Medical Professionals (BHMPS) maintain comprehensive records.	0% NC	N/A	N/A	N/A
QM19: The Contractor monitors that comprehensive records include at a minimum: identification information; demographic information; member initial and past medical histories.	70% PC	N/A	N/A	N/A
QM20: The Contractor monitors that BHMPs maintain comprehensive records that include at a minimum: identification information; demographic information; member initial and past medical and dental histories; and immunization records.	85% SC	85% SC	100% FC	100% FC
QM21: The Contractor monitors that PCPs maintain comprehensive records that include at a minimum: current problem listing; current medications; current and complete EPSDT forms; documentation of coordination of care; and information releases.	80% SC	N/A	N/A	N/A
QM22: The Contractor monitors that BHMPs maintain comprehensive records that include at a minimum: current problem listing; current medications; current and complete EPSDT forms, if applicable; documentation of coordination of care; and information releases.	45% NC	90% FC	100% FC	100% FC
QM23: The Contractor monitors that providers document in the member's medical record whether or not the adult member has been provided information on advance directives and whether an advance directive has been executed.	100% FC	50% PC	100% FC	100% FC
QM24: The Contractor ensures that there is appropriate supervision by a licensed professional (e.g. Physicians Assistants under supervision of a DO or MD or behavioral health technician, behavioral health paraprofessional under supervision of an independently licensed behavioral health professional). Does not include independent providers.	33% NC	N/A	N/A	N/A
QM25: The Contractor provides ongoing medically necessary nursing services for members who, due to their mental health status, are incapable or unwilling to manage their medical condition when the member has a skilled medical need.	100% FC	N/A	N/A	N/A
QM26: Primary Care Providers (PCP) are informed that they may medically manage behavioral health members for the treatment of anxiety, depression and Attention Deficit/Hyperactive Disorders (ADHD) and are informed about the coverage of medications to treat depression, anxiety and Attention Deficit/Hyperactive Disorders (ADHD) by the Contractor.	100% FC	N/A	N/A	N/A
QM27: The Contractor ensures that training and education is available to PCPs regarding behavioral health referrals and consultation procedures members identified as having behavioral health needs.	50% PC	N/A	N/A	N/A
QM28: The Contractor ensures that its quality management program incorporates the monitoring of the PCPs' medical management of behavioral health disorders (anxiety, depression and Attention Deficit/Hyperactive Disorder (ADHD).	100% FC	N/A	N/A	N/A
QM29: The Contractor ensures the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services.	NA	N/A	N/A	N/A

ADHS/DBHS Standard	MMIC	NARBHA	Cenpatico	CPSA
QM30: The Contractor incorporates industry best practices/evidence-based guidelines or AHCCCS endorsed "Tool Kits" for the treatment of anxiety, depression and ADHD.	0% NC	N/A	N/A	N/A
QM31: The Contractor collaborates with the Arizona State Hospital prior to member discharge.	100% FC	N/A	N/A	N/A
QM35: The Contractor conducts PIPs to assess the quality and appropriateness of its service provision and to improve performance.	0% NC	100% FC	100% FC	100% FC
QM36: The Contractor has a policy and procedure that monitors appointment availability, in-office wait time, and transportation wait times. The Contractor's policy and protocol includes corrective action plans for non-compliance with the requirements.	0% NC	N/A	N/A	N/A
QM37: The Contractor monitors that PCPs (integrated RBHA), Behavioral Health Medical Professionals (BHMPS), and organizational providers maintain comprehensive records.	100% FC	N/A	N/A	N/A
QM38: The Integrated RBHA Contractor monitors that PCPs maintain comprehensive records that include at a minimum: identification information; demographic information; member initial and past medical and dental histories; and immunization records.	100% FC	N/A	N/A	N/A

RBHAs will be placed on a Corrective Action Plan for all Standards falling below a score of 90%. The CAP will be lifted upon two consecutive quarters of acceptable improvement.

Full Compliance (FC):	90-100%
Substantial Compliance (SC):	75-89%
Partial Compliance (PC):	50-74%
Non-Compliance (NC):	0-49%
Not Scored (NS)/Information Only (IO):	Not Scored - baseline year
Not Applicable	N/A – Integrated Provider

Table # 35: FY14 Preliminary Scores for T/RBHA Administrative Review Results

ADHS/DBHS Standard	Gila River	Pascua Yaqui	WMAT
QM1: The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for member/system resolution.	100% FC	25% NC	0% NC
QM2: The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for system improvement.	100% FC	30% NC	0% NC
QM5: The governing body and the Contractor are accountable for all Quality Management/Quality Improvement (QM/QI) program functions.	100% FC	100% FC	0% NC
QM6: The Contractor has the appropriate staff employed to carry out Quality Management Program administrative requirements.	100% FC	67% PC	0% NC
QM7: The Contractor has a structure in place for a Quality Management Program that includes administrative requirements related to policy development.	100% FC	100% FC	0% NC
QM9: The Contractor ensures credentialing, re-credentialing, and provisional credentialing of the providers in their contracted provider network.	100% FC	100% FC	40% NC
QM10: The Contractor's provisional credentialing process meets the AHCCCS required timelines.	100% FC	100% FC	0% NC
QM11: The Contractor ensures the credentialing and re-credentialing of providers in the contracted provider network.	100% FC	0% NC	0% NC
QM12: The Contractor has a process for verifying credentials of all organizational providers. (Including but not limited to: hospitals, behavioral health residential treatment facilities, transportation, attendant care, group homes, etc.)	100% FC	0% NC	0% NC
QM13: The Contractor has a structure in place for a Quality Management Program that includes administrative requirements for oversight and accountability for all functions and responsibilities described in ADHS/DBHS Policy and AMPM Chapter 900 that are delegated to other entities.	100% FC	0% NC	0% NC
QM16: The Contractor maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its QM/QI Program.	0% NC	0% NC	0% NC
QM17: The health information system data elements include at least the following information to guide the selection of and meet the data collection requirements for quality improvement requirements.	100% FC	25% NC	0% NC
QM19: The Contractor monitors that comprehensive records include at a minimum: identification information; demographic information; member initial and past medical histories.	100% FC	85% SC	100% FC
QM20: The Contractor monitors that BHMPs maintain comprehensive records that include at a minimum: identification information; demographic information; member initial and past medical and dental histories; and immunization records.	100% FC	70% PC	80% SC
QM22: The Contractor monitors that BHMPs maintain comprehensive records that include at a minimum: current problem listing; current medications; current and complete EPSDT forms, if applicable; documentation of coordination of care; and information releases.	100% FC	75% SC	70% PC

ADHS/DBHS Standard	Gila River	Pascua Yaqui	WMAT
QM23: The Contractor monitors that providers document in the member's medical record whether or not the adult member has been provided information on advance directives and whether an advance directive has been executed.	100% FC	0% NC	0% NC
QM24: The Contractor ensures that there is appropriate supervision by a licensed professional (e.g. Physicians Assistants under supervision of a DO or MD or behavioral health technician, behavioral health paraprofessional under supervision of an independently licensed behavioral health professional). Does not include independent providers.	100% FC	0% NC	0% NC

- Full Compliance (FC): 90-100%
- Substantial Compliance (SC): 75-89%
- Partial Compliance (PC): 50-74%
- Non-Compliance (NC): 0-49%
- Information Only (I/O): Not Scored - baseline year

Mid-year Onsite Monitoring and Oversight Visits:

In CY13, DBHS/BQ&I conducted a mid-year site visit to monitor T/RBHA compliance with those AHCCCS Contractual monitoring and oversight requirements not captured during the Administrative Review. DBHS staff also monitors progress on all Administrative Review CAPs, RBHA-initiated CAPs, and additional corrective action plans issued by DBHS, as appropriate

DBHS did not conduct a mid-year site visit due to the transition of the integrated service delivery system in Maricopa County. The changes in processes required a significant increase in technical assistance, which impeded a mid-year site visit for CY14.

Quality of Care

Peer Review

ADHS/DBHS adhered to Quality of Care Review requirements in accordance with AHCCCS AMPM and the ADHS/DBHS QOC Policy (DBHS-Policy 1003 Peer Review and DBHS-Policy 1004 Quality of Care Concerns by:

- Conducting regular Peer Review meetings with Chief Medical Officer, Deputy Chief Medical Officer, and DBHS QOC team staff basis to ensure consistent review of QOC investigation findings, corrective actions, and recommendations.
- Monitoring the T/RBHAs Incident, Accident, and Death Reports review process to ensure
  - Investigation of all unexpected deaths
  - Investigation of all questionable incidents an accidents reported
  - DBHS developed a standardized report template for IAD complaint analysis and included it in the BQI Specification Manual to further strengthen the use of this data in RBHA QM programs.

- Monitoring T/RBHA tracking and trending of QOC concerns and QOC corrective action plans during annual Administrative Review
- Providing oversight of each T/RBHA's QOC policy and QOC process.
- Conducting focused reviews of QOC cases that previously resulted in a CAP
- Presenting oversight and monitoring results to the ADHS/DBHS QM Committee Meeting for discussion and recommendations

ADHS/DBHS ensured RBHA compliance with Peer Review requirements by:

- Reviewing policies and protocols
- Reviewing Committee agendas to ensure that Peer Review meetings are held, at a minimum, on a quarterly basis
- Reviewing the sign-in/Confidentiality Statement to ensure there is no breach in confidentiality,
- Verifying that meeting minutes are signed and approved by the RBHA Chief Medical Officer

ADHS/DBHS monitored the service delivery system to improve services for behavioral health recipients. These efforts focused not only on the frequency that ADHS/DBHS QM reviews contractor data, validation reviews, and implements corrective actions, but on the process used to monitor T/RBHA activities.

ADHS/DBHS developed five (5) strategies to meet the goal on monitoring and oversight activities. This goal was met through DBHS performing the following activities:

- Review of T/RBHA QM Plans
- Oversight of RBHA Provider Monitoring Activities
- Oversight of T/RBHA QOC and IAD Processes
- Oversight of RBHA Peer Review Process

Oversight of RBHA IAD and QOC Process: T/RBHAs are responsible for reviewing all IAD's to determine if there is a quality of care concern. RBHAs shall have written protocols outlining processes for the receipt, review, and comprehensive tracking of (IAD's). DBHS audited these documents and processes as part of the oversight and monitoring function. As a part of the RBHA's process for reviewing and evaluating IADs and member and provider issues, the T/RBHA has ongoing resolution process of quality of care issues that include the following:

- Documentation of each issue raised, when and from whom it was received, and the timeframe expected for resolution.
- An investigation and report to DBHS of all unexpected deaths and suicides; potentially high profile cases, allegations of abuse, neglect, or exploitation by a provider agency, health care acquired conditions (HCAC), and other provider-preventable conditions (OPPC), as outlined in the AHCCCS AMPM, Ch. 900.
- Timeframe for resolution of routine investigations is no more than 30 calendar days. RBHAs are responsible for initiating, investigating, analyzing, and reporting all quality of care investigations within the prescribed timeframe.

ADHS/DBHS QOC staff provided on-site oversight of each T/RBHA's QOC policy and QOC protocols during the Annual Administrative Review (see T/RBHA Administrative Review results above)

Credentialing

ADHS/DBHS conducted Annual Administrative Review of the T/RBHAs to assess Credentialing processes by:

- Reviewing policies and protocols
- Validating a sample of T/RBHA provisional, organizational and individual credentialing and re-credentialing records (see T/RBHA Administrative Review results above)

T/RBHAs are contractually obligated to complete organizational and provider credentialing (including provisional credentialing, initial credentialing, and re-credentialing) for all of their providers in a timely manner. DBHS provides oversight/monitoring through quarterly credentialing reports and credentialing review during the Administrative Review process. The DBHS-Desktop Protocol-Credentialing and Recredentialing (Attachment E) explains the quarterly credentialing report. Contractors must develop and implement credentialing policies, procedures and protocols that meet AHCCCS and DBHS requirements. Contractors are expected to review all completed credentialing, re-credentialing, and provisional credentialing applications in their Credentialing Committee, and to bring issues/concerns to their QM or Peer Review Committee as applicable. The T/RBHA Chief Medical Officer (CMO) is responsible for chairing these committees and implementing decisions made by these committees. DBHS reviews QM Committee and Credentialing Committee meeting minutes as part of the oversight function during the Administrative Review DBHS reviews credentialing information provided by the T/RBHAs and discusses credentialing activities in the QM Committee Meeting. Specific findings that require additional recommendations or actions will be referred to and reviewed by the DBHS Peer Review Committee (PRC). DBHS will alert the T/RBHA of potential Provider and/or Organizational concerns identified as a result of this process.

In addition, each RBHA must sub-contract with the AHCCCS mandated Credentialing Verification Organization (CVO), the purpose of which is to ease the administrative burden for providers that contract with multiple AHCCCS-DBHS Contractors. Use of the CVO will decrease duplicative submission of information used for credentialing purposes.

Contractors must have policies and procedures to address granting of temporary or provisional credentialing when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process. Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. Contractors shall have 14 days from receipt of a complete application within which to render a decision regarding temporary or provisional credentialing regarding this process.

DBHS provides oversight, monitoring and technical assistance when needed. Contractors' credentialing processes and files (a random sample of 30 files for each type of credentialing) are reviewed during the DBHS Annual Administrative Review.

Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-alike Center, as well as hospital-employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

Processes must include records of onsite inspections of non-licensed providers to ensure compliance with credentialing requirements. The credentialing process must include a mechanism for providers to appeal credentialing decisions. Contractors must appropriately re-credential their subcontracted providers every three years, and must have a process in place to verify licenses during interim years.

DBHS mandates that the Contractors utilize the DBHS Credentialing and Re-credentialing Tools (Attachment E) for all credentialing activities for all provider types. DBHS Policy 405: Credentialing and Recredentialing (Attachment F) outlines DBHS' requirements for the Contractors.

Contractors must utilize their Contractor Credentialing Committee, Peer Review Committee or similar body to oversee credentialing and re-credentialing decisions. The Contractor's Medical Director or other designated physician is responsible for oversight of the credentialing process. Contractors must utilize participating Arizona Medicaid network providers in making credentialing decisions. As part of their re-credentialing process, contractors are to assure that they have tracked and trended the utilization, complaints, grievance and appeals, and medical record review data as part of their decision making process.

Contractors are required to submit to DBHS a quarterly Credentialing Report using the Credentialing Template located in the BQ&I Specifications Manual (Attachment K) (http://www.azdhs.gov/bhs/bqmo/specifications-manual.htm). DBHS will assemble and submit to AHCCCS a combined T/RBHA Credentialing Report on a quarterly basis. Issues related to the tracked and trended data as indicated above must be included in the contractor's quarterly submission to DBHS, who in turn, will provide the information to AHCCCS.

Medical Record Review

OPI validated the Medical Records from all of the T/RBHAs based upon the required documents on the Standards. Results of the Medical Record Review are located on pages 38-42 of this document. Those T/RBHAs scoring below full compliance will be responsible for writing corrective action plans (CAPs). These plans will include a work plan outlining the goal, interventions, actions, responsible party, and due date for each CAP.

VIII. Goal 7: Performance Framework and Dashboard

The BQ&I Office of Information Management prepares and presents key social and clinical indicator information with DBHS stakeholders and the general public through updates to its Performance Framework and Dashboard, available on the ADHS website. This vehicle is designed for sharing accurate, timely data that compares performance and outcomes across RBHAs. This vehicle also was developed to promote transparency, accountability, and strategic planning of interventions to improve performance across the system.

The Performance Framework and Dashboard was redesigned in FY2014 to reflect changes made to the AHCCCS Performance Measures for FY2014. However, due to ongoing revisions to the methodologies of some performance measures, and required work to improve the quality of AHCCCS' encounter data that is used to calculate performance for most of the Dashboard metrics, OIM has been unable to fulfill its commitment to timely updates during FY2014. The Office of Information Management will resume quarterly and annual updates to the Dashboard when AHCCCS and DBHS have resolved the issues that currently prevent the transfer of encounter data from AHCCCS to DBHS.

The current Dashboard content is organized into four categories:

- Outcomes – Impact on Quality of Life
- Access to Services
- Service Delivery
- Coordination/Collaboration

Within these categories are representative measures from various sources. Outcomes are reported from the National Outcomes Measures, an annual review based on demographic data submitted by the RBHAs. The Annual Consumer Survey, annual geomapping, and one performance measure contribute to the Access to Services category. Service Delivery is sourced from the Annual Consumer Survey and two performance measures, and the Coordination/Collaboration category includes one performance measure and utilization data.

To ensure that the Dashboard continues to reflect important and key performance indicators, the addition of a number of HEDIS measures to the list of AHCCCS performance measures in FY2014 necessitated the Office of Information Management to developed additional processes and structures to facilitate routine, meaningful, and comprehensive updates to the Dashboard: All performance measures and subordinating sources were evaluated and specific measures were identified as appropriate for regular presentation on the Dashboard. The *FY2013 Dashboard Checklist* was revised, to accommodate the new HEDIS measures and BQ&I processes to reflect changes in the 2014 Dashboard protocol. Modifications include the requirement that all metrics be presented to DBHS' Quality Management and/or Medical/Utilization Management Committee, before being posted on the Dashboard to ensure that information shared on the Dashboard is reviewed, approved, and supported by DBHS' leadership.

Challenges that to date have not been fully reconciled and prevent OIM from meeting the Dashboard update schedule outlined in DBHS' FY2014 Work Plan include changes to the methodologies for both the behavioral and HEDIS measures, e.g., changes to or yet undefined value sets and MPSs. Additionally, some measures that require a rolling year cannot be effectively measured because the new RBHA for GSA 6 has not been providing services long enough to complete an entire rolling year period.

Incomplete encounter data DBHS receives from AHCCCS is currently being aggressively addressed. In the meanwhile, use of administrative data has been suspended until encounter issues are resolved. Dashboard measures contingent on encounters will be updated at that time, along with FY2014 annual updates related to the National Outcome Measures, Consumer Survey, and geo-mapping.

Goal partially met

IX. Conclusion

Based on ADHS/DBHS evaluation of strategies and activities carried out during FY14, all of the goals were not met. However, areas of improvement were identified and the FY15 work plan has been developed with measurable goals and strategies. ADHS/DBHS will be able to measure the effectiveness of implementation strategies that were identified in the FY15 work plan.

ADHS/DBHS incorporated member and family input into the QM program by inviting providers, members, and family to participate in the quarterly T/RBHA QM Coordinators Committee Meeting in Q4 of CY14. Provider and member/family participation for the first meeting was scant, and misunderstandings occurred at the RBHAs as to allowing participation from Providers/members/family requesting inclusion in the meeting. OPI and the OIFA developed a process to increase community participation. Providers, members and family will be invited to attend meeting quarterly. Information received from the community participants will be tracked, trended and shared at the QM Committee Meeting. PIPs will be developed to address issues negatively impacting member quality of care and service.
DBHS began Integrated RBHA services (Mercy Maricopa Integrated Care – MMIC) for Maricopa County in April 2014. Readiness efforts consisted of documentation review, technical assistance meetings, etc. to assure that MMIC was well-equipped to facilitate the care and treatment of Maricopa behavioral health members. In addition, AHCCCS monitored DBHS readiness efforts with MMIC to ensure that DBHS had effectively put into place all of the tools necessary to monitor MMIC. Lessons learned from the implementation of the Maricopa Integrated RBHA were applied to the request for proposal (RFP) for the Greater Arizona Integrated RBHA Contract, which is scheduled to begin October 01, 2015.

Leadership changes; Office restructuring within BQ&I; staffing adjustments to increase the FTEs allowed for hiring staff with specialized expertise; focused TA from AHCCCS; advances in departmental-wide data analysis are some of the changes experienced by BQ&I which resulted in greater focus on member care and service delivery.